DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 01 - 003
2. STATE: Alaska
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: January 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250 - 447.252 and 42 CFR 447.256 - 447.299

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ ~~51,500~~ 0 (P&I)
b. FFY ~~2001~~ 2002 $ 0 (P&I)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A

10. SUBJECT OF AMENDMENT:
New rate setting methodology.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Does not wish to comment

12. SIGNATURE OF STATE AGENCY OFFICIAL:
for

13. TYPED NAME: Bob Labbe

14. TITLE: Director, Division of Medical Assistance

15. DATE SUBMITTED: ~~September 29, 2000~~ March 30, 2001 (P&I)

16. RETURN TO:
Division of Medical Assistance
P.O. Box 110660
Juneau, Alaska 99811-0660

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: 28

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 1 2001

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: TERESA L. TRIMBLE

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID AND ...

23. REMARKS:
P&I changes authorized by the State on 6/30/01.
POSTMARKED 3/30 (DATE) Anchorage (CITY)

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN FOR MEDICAID PROVIDER REIMBURSEMENT

INPATIENT HOSPITAL

Inpatient hospital services provided by acute care, specialty, and psychiatric hospitals are paid for Medicaid recipients by means of rates determined in accordance with the following principles, methods and standards which comply with [42 CFR 447.250 THROUGH 477.299] 1902(a)(13)(A), 1902(a)(30), and 1923 of the Social Security Act and Federal regulations at 42 CFR 447.250 through .252, .256, .257, .272, .280, and .296 through .299.

I Introduction:

Rate setting principles and methods are contained in Alaska Statutes 47.07.070 - 47.07.900 and administrative regulations in Alaska Administrative Code 7 AAC 43.

For purposes of this section the following definitions apply:

1. Acute Care Hospital – means a facility that provides inpatient hospitalization for medical and surgical care of acute illness or injury and perinatal care.

2. Specialty Hospital – means a rehabilitation hospital that is operated primarily for the purpose of inpatient care assisting in the restoration of persons with physical handicaps.

3. Psychiatric Hospital – means a facility that primarily provides inpatient psychiatric services for the diagnosis and treatment of mental illness; "psychiatric hospital" does not include a residential treatment center.

Data sources used by the Medicaid Rate Advisory Commission and the Department of Health and Social Services (the Department) are the following:

1. For facilities whose fiscal years begin January 1, 2001 through December 31, 2001, the department will use the as filed reports as outlined in numbers 2-5 of this Subsection from the facility's fiscal year ending during calendar year 1999 and the department-generated MR-0-14 report which includes claims data processed no later than September 26, 2000.

2. When rebasing occurs, the Medicare Cost Report for the facility's fiscal year ending 24 months before the beginning of the year that is rebased.

3. Budgeted capital costs, submitted by the facility and reviewed and adjusted by the Department as appropriate in accordance with Section II, for the rate year on
capital projects or acquisitions which are placed in service after the base year and before the end of the rate year and for which an approved Certificate of Need has been obtained.

4. Year end reports which contain historical financial and statistical information submitted by facility's for past rate setting years.

5. Utilization and payment history report (commonly known as the MR-0-14) provided by the Division of Medical Assistance.

II Allowable Costs:

Allowable costs are documented costs that are ordinary and necessary in the delivery of a cost effective service. Allowable costs are those which directly relate to Title XIX program recipients. Costs would include those necessary to conform with the state and federal laws, regulations, and quality and safety standards.

Most of the elements of Medicaid allowable costs are defined in Medicare and reported, subject to audit, on the Medicare Cost Report. The following items are possible adjustments from financial statement classifications to Medicaid classifications, and may be reflected either within the Medicare Cost Report or elsewhere in the Medicaid cost finding process.

* return on investment is not an allowable cost for any facility.

* advertising cost is allowable only to the extent that the advertising is directly related to patient care. The reasonable cost of only the following types of advertising and marketing is allowable:
  - announcing the opening of or change of name of a facility.
  - recruiting for personnel.
  - advertising for the procurement or sale of items.
  - obtaining bids for construction or renovation.
  - advertising for a bond issue.
  - informational listing of the provider in a telephone directory.
  - listing a facility's hours of operation.
  - advertising specifically required as a part of a facility's accreditation process.

* physician compensation costs and related charges associated with providing care to patients are not allowable for purposes of calculating a prospective payment rate.

* medical services which a facility or unit of a facility is not licensed to provide are not included as an allowable cost.

* costs not authorized by a certificate of need when a certificate of need is required are not included as an allowable cost.

Allowable patient related costs include wages, salaries, and employee benefits, purchased services; supplies; utilities, depreciation, rentals, leases; taxes, excluding local, state and federal income taxes; and interest expense. A facility must reduce operating costs by the cost of all activities not directly related to health care. Other specific non allowed costs are bad debts, charity, contractual adjustments and discounts taken by payers.

If a certificate of need is required on assets purchased after July 1, 1990, the amount of capital costs included in the rate calculation will be limited to the amounts described within the certificate of need application and other information the facility provided as a basis for approval of the certificate of need. In determining whether capital costs exceed those amounts approved under a certificate of need, the department will consider:

(1) the terms of issuance describing the nature and extent of the activities authorized by the certificate; and

(2) the facts and assertions presented by the facility within the application and certificate of need review record, including purchase or contract prices, the rate of interest identified or assumed for any borrowed capital, lease costs, donations, developmental costs, staffing and administration costs, and other information the facility provided as a basis for approval of the certificate of need.

III Inflation Adjustments:

Allowable base year costs are adjusted for inflation. For acute care, specialty, and psychiatric facilities the inflation adjustment for allowable non-capital costs for fiscal year 2000 is 2.6% and for fiscal year 2001, 2.7%. For the facilities' allowable capital and allowable home office capital costs the inflation adjustment for fiscal years 2000 and 2001 is 1.1%.

For fiscal years after 2001, the department will utilize the most recent quarterly publication of Standard and Poor's "DRI Health Care Cost Review" available 60 days before the beginning of a facility's fiscal year. For the inflation adjustment relating to

allowable non-capital costs, the department will utilize the DRI Type Hospital Market Basket. Allowable capital and allowable home office capital will be adjusted using the Skilled Nursing Facility Total Market Basket Capital Cost component.

IV Determination of Prospective Payment Rates:

For prospective payment periods beginning after December 31, 2000, the prospective payment rate for inpatient hospital services rendered to Medicaid recipients is a per-day rate reflecting costs related to patient care and attributable to the Medicaid program. Prospective payment rates will be determined under one of three methodologies – Basic, Optional, and New Facilities.

a. Basic Prospective Payment Rate Methodology

The prospective payment rate consists of four components – costs excluding capital for routine cost centers, capital costs for routine cost centers, capital costs for ancillary cost centers, and costs excluding capital for ancillary cost centers. The prospective payment rates will be annual rates based on the facility's fiscal year. The base year for rate years beginning in calendar year 2001 will be the facility's fiscal year ending during calendar year 1999. After this initial rate year and except for facilities electing to be reimbursed under the optional payment rate methodology detailed in Subsection IVb, re-basing will occur for all facilities no less than every four years.

The prospective per-day rates for inpatient acute care, specialty, and psychiatric hospitals are computed as follows:

1. Total allowable base year costs excluding capital costs for each routine cost center are divided by the total inpatient days in that cost center and the resulting per-day cost is multiplied by allowable paid Medicaid days in that cost center to arrive at Medicaid allowable base year routine costs for that cost center. The sum of the Medicaid allowable base year costs for all routine cost centers are divided by the sum of the allowable paid Medicaid inpatient days for all routine cost centers resulting in the facility's base year Medicaid specific non-capital routine cost per-day.

2. Total allowable base year capital costs for each routine cost center are divided by the total inpatient days in that cost center and the resulting per-day cost is multiplied by allowable paid Medicaid days in that cost center to arrive at Medicaid allowable base year routine capital costs for that cost center. The sum of the Medicaid

allowable base year capital costs for all routine cost centers are divided by the sum of the allowable paid Medicaid inpatient days for all routine cost centers resulting in the facility's base year Medicaid specific capital routine cost per-day.

3. The percentage of base year capital costs in each ancillary cost center is applied to the Medicaid ancillary costs for the cost center calculated by first dividing allowable ancillary costs by total inpatient days and applying the resulting per-day costs to paid Medicaid inpatient days. The sum of the Medicaid allowable capital costs for all ancillary cost centers is divided by the sum of the allowable paid Medicaid inpatient days for all ancillary cost centers resulting in the facility's base year Medicaid specific capital ancillary cost per day.

4. The sum of the Medicaid allowable capital costs for all ancillary cost centers determined in 3. is removed from the total base year Medicaid specific ancillary costs determined by dividing total base year ancillary costs by total inpatient days and applying the resulting amount to total paid Medicaid inpatient days. The resulting base year allowable ancillary cost is then divided by paid Medicaid inpatient days to arrive at the facility's base year Medicaid specific non-capital ancillary cost per-day.

Each base year component rate is then adjusted for inflation in accordance with Section III and summed to arrive at the facility's prospective payment rate.

The capital components of the prospective payment rate will be adjusted to reflect appropriate capital costs for the prospective year based on certificate of need documentation, assets retired in conjunction with the certificate of need, and Medicare cost reporting requirements.

For purposes of determining prospective payment rates, nursery days constitute inpatient days and swing-bed days do not constitute inpatient days. Costs and charges associated with swing-bed services, determined by applying the swing-bed rate in the base year to the number of swing-bed days, are removed prior to calculating the prospective payment rate. For the routine cost centers, the Medicaid inpatient days are the covered days from payment history reports generated by the Division of Medical Assistance (commonly known as the MR-0-14). For the ancillary cost centers, Medicaid inpatient days will be those days reported in the facility's Medicare Cost report. When rebasing occurs, either the facility reported Medicaid audited days or covered days from the payment history reports will be used for ancillary cost centers.

Prospective payment rates for facilities that are calculated and paid on a per-day basis as discussed in this Section will be no greater than the per-day rates proposed in the certificate of need application and other information provided as a basis for approval of the certificate of need for the first year during which the following are available for use and for two years immediately following the first year:

(1) opening of a new or modified health care facility;
(2) alteration of bed capacity; or
(3) the implementation date of a change in offered categories of health service or bed capacity.

If a facility is granted a certificate of need for additional beds, the additional capital payment add-on to the per-day rate will include the base year's inpatient days plus additional days associated with the additional beds. The additional days are calculated as the base year's occupancy percentage multiplied by 80 percent and then multiplied by the additional beds approved in the certificate of need. The resulting figure is further multiplied by 365.

Except for critical access hospitals, costs are the lower of costs or charges in the aggregate to the general public. For the initial prospective payment year, routine charges are those in the payment history reports and ancillary charges are those reported by the facility.

b. Optional Prospective Payment Rate Methodology and Criteria for Small Facilities

A facility that had 4,000 or fewer total inpatient hospital days as an acute care, specialty or psychiatric hospital, or as a combined hospital-nursing facility during the facility's fiscal year that ended 24 months before the beginning of its prospective payment rate year during calendar year 2001 may elect to be reimbursed for inpatient hospital services under provisions of this Subsection. If a facility that meets this criteria does not elect to participate during its first fiscal year after December 31, 2000, the facility may not elect to participate under the provisions of this Subsection until after a re-basing occurs under the provisions of Subsection IVa.

If a facility that elected to be reimbursed under the prior Optional Payment Rate Methodology for Small Hospitals for its payment years beginning in calendar year 1998 until the last day of its fiscal year ending during the period of July 1, 2001 through June 30, 2002, does not elect to participate after its agreement expires or does not terminate the agreement for its first fiscal year beginning after December 31, 2000, the facility may not elect to participate under the provisions of this Subsection until after a re-basing occurs under the provisions of Subsection IVa.

Its prospective payment rate will be determined pursuant to Subsection IVa until rebasing has been executed.

A facility electing to be reimbursed under this Subsection must have an agreement with the department that will not expire, lapse, or be revoked before four facility fiscal years have lapsed. The agreement may be renewed after it expires if the facility still qualifies for reimbursement under this Subsection. A re-basing of the prospective payment rate for the renewed agreement will occur in accordance with Subsection IV.

For a facility that was not reimbursed under the Optional Payment Rate Methodology for Small Hospitals prior to its first fiscal year beginning after December 31, 2000, that elects to be reimbursed under this Subsection rather than Subsection IVa, its prospective payment rate will be based on its 1999 established rate or the rate calculated under Subsection IVa at the election of the facility. If the facility elects its 1999 payment rate, its initial year prospective payment rate during calendar year 2001 will be determined as follows:

(1) The prospective payment rate will be expressed as a per-day rate, composed of separate capital and non-capital components.

(2) The capital component is calculated by dividing the facility's Medicaid capital per adjusted admission reflected in its 1999 payment rate by the average Medicaid length of stay and adjusted for inflation by 1.1 percent per year for each fiscal year after the first year of election and ends at the expiration of its agreement.

(3) The non-capital component is calculated by dividing the facility's allowable Medicaid costs per adjusted admission by the facility's average Medicaid length of stay, and subtracting the capital component from the quotient. The resulting amount is adjusted for inflation at three percent per year for each fiscal year after the first year of election and ends at the expiration of the agreement.

For a facility that was not reimbursed under the Optional Payment Rate Methodology for Small Hospitals prior to its first fiscal year beginning after December 31, 2000, that elects to be reimbursed under this Subsection under the provisions of Subsection IVa, its prospective payment rate for the first year beginning in calendar year 2001 and each year thereafter until the facility's agreement expires will be determined pursuant to Subsection IVa except that the non-capital and capital components of the payment rate will be adjusted annually for inflation after the first year by 3 percent and 1.1 percent respectively.

Increases in the capital component of the prospective payment rate for new assets placed in service during the period covered by the agreement will be allowed based on the provisions in Subsection IVa if the following conditions are met:

(1) the assets placed into service have a value of at least $1,000,000;

(2) the facility obtains one or more certificates of need for the assets placed into service; and

(3) the facility provides a detailed budget before the increase in the prospective payment rate that reflects the allowance for the new assets.

The administrative appeals process provided under Subsection VIII is not available and the facility will use the "exceptional relief" process pursuant to Subsection XII except in the case that the facility disputes an action or decision of the department that relates to the following:

(1) the facility's eligibility to elect rate setting under this Subsection;

(2) the violation of a term of the rate agreement between the facility and the department;

(3) the denial of an increase in the prospective payment rate based on a determination on an increase in the capital component of the prospective payment rate for new assets and a related approved certificate of need.

For the prospective rate year beginning in calendar year 2001, 95 percent of the facility's 1999 Medicaid non-cross-over allowed total dollar amount from the MR-0-14, as of 180 days after the end of the facility's 1999 fiscal year, will be compared the facility's 2001 allowed total dollar amount from the MR-0-14, as of 180 days after the end of the facility's 2001 fiscal year. If the adjusted 1999 amount exceeds the 2001 amount, the facility will receive a lump sum payment for the difference.

c. New Facility Prospective Payment Rate Methodology

Under this Subsection, a new facility is described as a facility that has not, within the previous 36 months, provided the same or similar level of Medicaid certified patient services within 25 miles of the facility either through present or previous ownership.

If a new facility is licensed, the rates will be calculated as follows:

For acute care and specialty hospitals, the inpatient per-day rate ~~and the outpatient payment percentage~~ (P&I) will be established at the statewide weighted average of inpatient per-day rates ~~and outpatient payment percentages~~(P&I) of acute care and specialty hospitals in accordance with this section for the most recent 12 months of permanent rates; patient rates are the statewide weighted average using the base year's patient days. ~~and the outpatient percentages are the statewide weighted average using the base year's outpatient charges.~~(P&I)

For inpatient psychiatric hospitals, the inpatient prospective payment rate will be established at the statewide weighted average of inpatient per-day rates of psychiatric hospitals for the most recent 12 months of permanent rates; rates are the statewide weighted average using the base year's patient days.

Prospective payment rates for new facilities will be established under the provisions of Section IV after two full years of cost data is reported.

V Year End Review

To determine whether the actual rates used for payment to an acute care hospital, specialty hospital, or psychiatric hospital are in conformance with the established rates for the facility, the department will conduct a year-end review for prospective payment years beginning after December 31, 2000. The department will compare the established rate for the period ended 24 months before the beginning of the prospective rate year to the actual rate paid by the division of medical assistance to the facility. If the actual payments are different than the established rate, the department will adjust the payments to reflect the established rates.

The department may waive all or part of the year-end review adjustment calculated if the facility provides proof of manifest injustice resulting from the application of year-end review. Manifest injustice is based upon consideration of the following factors:

1. whether the facility has taken effective measures to control costs in response to the situation upon which the waiver is based;

2. whether the waiver request contradicts a prior action of the department as to an element of the facility's established rate;

3. whether the waiver would result in the payment for only allowable cost of services authorized by the division of medical assistance under state or federal laws;

4. whether the situation upon which the waiver request is based results from the provision of direct patient care or from prudent management actions improving the financial viability of the facility to provide patient care.

VI Sale of Facilities:

An appropriate allowance for depreciation, interest on capital indebtedness and (if applicable) return on equity capital for an asset of a facility which has undergone a change of ownership will be valued at the lesser of the allowance acquisition cost of the asset to the owner of record on or after July 18, 1984, or the acquisition cost of the asset to the new owner in accordance with Section 1861(v)(1)(O) of the Act. In addition, the recapture of depreciation expense on disposition of assets that accommodate gains under the Medicaid program will be limited by the provisions of Section 1861(v)(1)(O)(ii) of the Act. Payment for acquisition costs associated with buying and selling of the facility will be limited by the provisions of Section 1861(v)(1)(O)(iii) of the Act.

VII Adjustment to Rates:

All rates for facilities are set by the department with the advice of five Governor appointed Commissioners. The Commissioners are: a representative of the State of Alaska, a representative of the providers, a physician, a certified public accountant, and a consumer. Facilities have the opportunity to provide additional information on significant changes that would impact the rates.

The department on its own motion or at the request of an applicant may reconsider its actions within 30 days. There is nothing to preclude a facility from petitioning the department at any time during its fiscal year for additional consideration.

Reconsiderations are warranted only in those cases where the proper application of the methods and standards described in Attachment 4.19-A is in question or is being challenged.

VIII Provider Appeals:

If a party feels aggrieved as a result of the department's rate setting decisions, the party may appeal and request reconsideration or an administrative hearing. Administrative hearings are conducted by Governor appointed Hearing Officers. An administrative appeal must be filed within 30 days of the mailing of the decision of the department.

The Hearing Officer would hear a case in accordance with administrative law in the State of Alaska. The Hearing Officer would prepare draft findings, conclusions and order for the commissioner of the department's review. The commissioner of the department would review the findings of the Hearing Officer and may accept, reject, or modify the